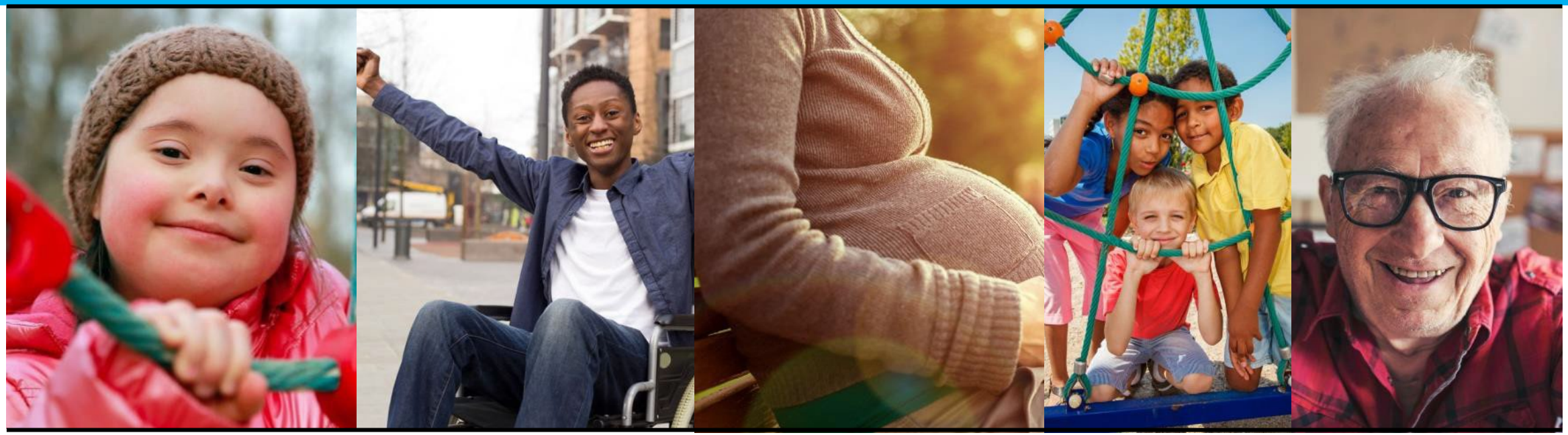


BOARD OF MEDICAID ASSISTANCE SERVICES
SEPTEMBER 2023

Cheryl Roberts, JD

Director, Department of Medical Assistance Services

Agenda

- Director Updates
- Unwinding Update
- Budget Update

Virginia Medicaid's Overarching Goals

Goal 1: Member-Centered
Serving members the best way possible

1. Improve maternal/child health outcomes
2. Ensure members with behavioral health needs obtain coordinated care and services
3. Support community living and independence for all older adults and people with disabilities who need help with daily activities

By

Goal 2: Innovating
To create new ways to address member and program needs

1. Explore and develop new models and services that drive outcomes
2. Foster a team of qualified and passionate public servants
3. Streamline the member journey and process from application to services to transitions
4. Use data and technology to make our program more efficient and effective

And

Goal 3: Accountable
Managing the Commonwealth's resources with integrity and measurable outcomes

1. Ensure program integrity and compliance with State and federal requirements
2. Increase accountability of contractors and partners to ensure a stable, accessible, and continuously improving program
3. Monitor fiscal integrity and accountability and manage risk

Who Do We Cover?

Medicaid plays a critical role in the lives of more than 2.152 million Virginians

Children 851,9493

Pregnant Members 38,610

Older Adults 87,095

Individuals with Disabilities 148,889

Adults 866,965

Limited Benefit Individuals 159,468

Source: September 1, 2023 DMAS Enrollment Dashboard - https://www.dmas.virginia.gov/data/medicaid-famis-enrollment/

DMAS Priorities: “3 for 2023”

1. **Unwinding:** Return to Normal Medicaid Redetermination Processing
2. ***Right Help, Right Now*:** Behavioral Health Transformation
3. **Procurement:** Medicaid Managed Care Delivery System Re-procurement

Impact of “Unwinding”

As of March 2023, Virginia began redetermining Medicaid eligibility for over 2.1 million members after a 3 year pause.

Preparations, execution and ongoing modifications for this work are a joint HHR effort in close collaboration with the Department of Social Services (DSS). The work is closely monitored by CMS.

DMAS expects approximately 14% of members to transition off the Medicaid program due to no longer meeting program requirements.

Asking for everyone’s assistance to assist members with completing renewal packets prior to redetermination deadlines!

RHRN: DMAS Engaged Across Six Workstreams

An aligned approach to BH that provides access to **timely, effective, and community-based care** to reduce the burden of mental health needs, developmental disabilities, and substance use disorders on Virginians and their families.

1: We must strive to ensure **same-day care for individuals experiencing behavioral health crises**

2: We must **relieve the law enforcement communities' burden** while providing care and **reduce the criminalization of behavioral health**

3: We must **develop more capacity** throughout the system, going beyond hospitals, especially to enhance community-based services

4: We must **provide targeted support for substance use disorder (SUD)** and efforts to prevent overdose

5: We must **make the behavioral health workforce a priority**, particularly in underserved communities

6: We must **identify service innovations and best practices** in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps

Source: VA HHR

DMAS Role in *Right Help. Right Now*. Planning

DMAS is on the Steering Committee and Co-Leads the workstream on Service Innovations.

As the largest payer of behavioral health services in the Commonwealth, DMAS is working with agencies across the Administration on all six areas of the plan.

- Prevention
- Crisis
- Substance abuse
- Population focus
- New models and services
- Quality and network adequacy
- Maximizing our Managed care contracts

Medicaid Managed Care Procurement

The health plans provide preventive, chronic, behavioral health and long-term services to to 94% of the Virginia Medicaid members.
To continue to build on the foundation and strengths of Virginia's Medicaid managed care, and maximize program enhancements for members and providers, DMAS is seeking to transform its managed care delivery system through a re-procurement.

A Medicaid managed care re-procurement process is an important and rare opportunity to leverage a state's purchasing power to improve the value that MCOs provide to the state and its members and provider networks.	In October 2022, HHR Secretary Littel announced that DMAS is seeking to use this procurement to drive innovation and strengthen quality and accountability in its managed care program.	DMAS worked with a nationally recognized consultant to translate the priorities of the Administration and emerging best practices into a targeted RFP that was released in August 2023 and aims to move the needle in key areas.	The procurement reflects DMAS' goals to improve services, delivery and access in Right Help Right Now Behavioral health focus, maternal and child health, member engagement, single specialty plan for foster care, innovation, new technology, performance and quality improvement incentives, new payment models and increased accountability.

RFP released August 31, 2023 for Summer 2024 implementation
Link can be found on eva.virginia.gov

Medicaid Managed Care Procurement

This RFP will support DMAS to achieve the following goals:

1. Advance the Commonwealth's priorities such as improving behavioral health and population health outcomes.
2. Provide member-centered holistic care that meaningfully engages and addresses unique needs of its members.
3. Enhance availability and accessibility of care across all care settings.
4. Enable participants utilizing LTSS to live in their setting of choice and promote their well-being and quality of life.
5. Strategically leverage new technologies, payment models, and best practices for accountability and impact.

Medicaid Managed Care Procurement

The methods by which DMAS will achieve these goals through this RFP include:

- Emphasis on health outcomes – not inputs.
- Bold innovations and effective use of managed care flexibilities and resources.
- Enhanced focus on health-related social needs (HRSN) to improve health.
- Robust and responsive care management and enhanced member engagement.
- Strategies to improve provider experience and engagement.
- Strategies to improve oversight, strengthen program integrity, and set reasonable profit margins.

Director Updates

- Workforce Updates
- Partnership for Petersburg
- Cardinal waiver and Provider Enrollment
- RAM Clinic and Southwest Provider Summit
- Foster Care Kids go to College
- Bon Secours Contract
- State Base Exchange approved by CMS
- DOJ update

VIRGINIA MEDICAID UNWINDING:
ENDING CONTINUOUS COVERAGE REQUIREMENTS AND THE RETURN TO NORMAL ENROLLMENT

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

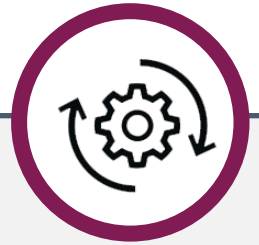
VIRGINIA'S MEDICAID PROGRAM DMAS

CardinalCare Virginia's Medicaid Program

COVER VIRGINIA

Medicaid Enrollment in the Commonwealth

The end of the continuous coverage requirement in the Commonwealth will present the single largest health coverage event since the first open enrollment of the Affordable Care Act (ACA). This event is also known as unwinding.



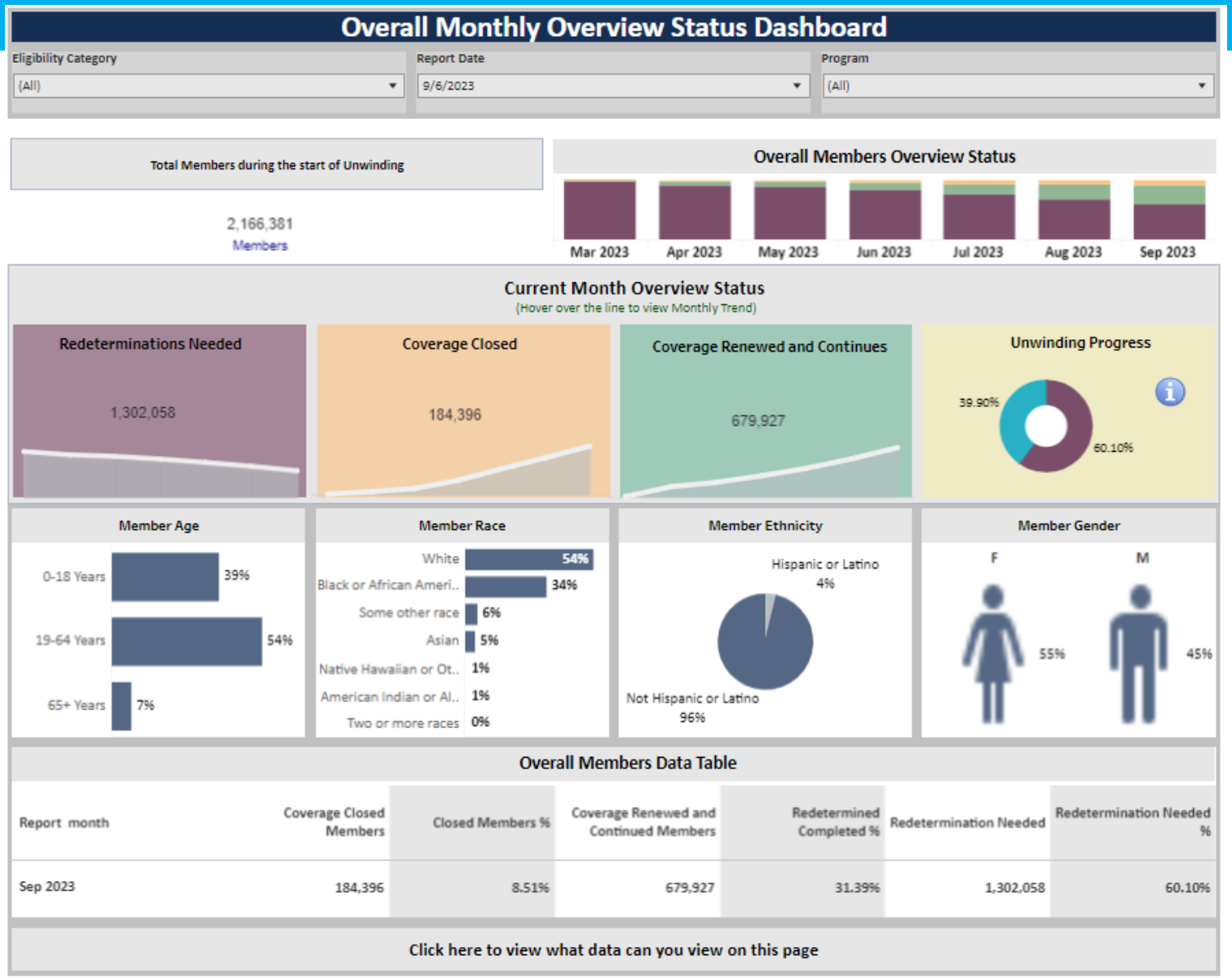
Historically, the Commonwealth has experienced **churn, which is enrollees who reapply and re-gain coverage shortly after being terminated**.

From March 2020 through March 1, 2023, the Commonwealth experienced an **increase of over 630,000 enrollees (a 41% increase in enrollment growth).**

Enrollment growth has been the **fastest among non-elderly, non-disabled adults**, and slower among children and aged, blind, and disabled (ABD) eligibility groups.

Post continuous coverage, **roughly 14% of the state's total Medicaid enrollees may lose coverage, and up to 4% of members may lose and regain coverage within 1-6 months of closure. The national average for loss is around 20%.**

Unwinding Data



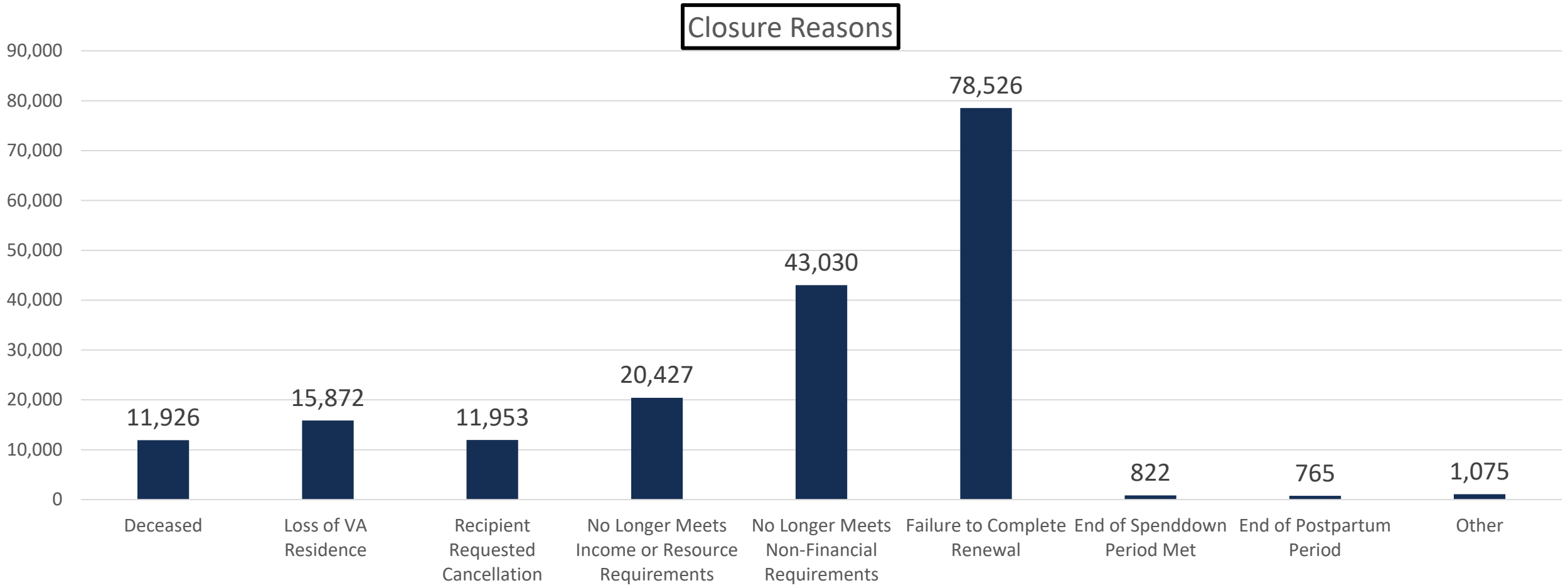
* Data from dashboard as of 09/06/2023 – 184,396 members were closed, and 679,927 members were renewed with ongoing coverage as of 09/06/2023.

864,323 Members Determined as of 09/06/2023*

Completed by Member
2,166,831
2,000,000
1,900,000
1,800,000
1,700,000
1,600,000
1,500,000
1,400,000
1,300,000
1,200,000
1,000,000
900,000
864,323
700,000
600,000
500,000
400,000
300,000
200,000
100,000

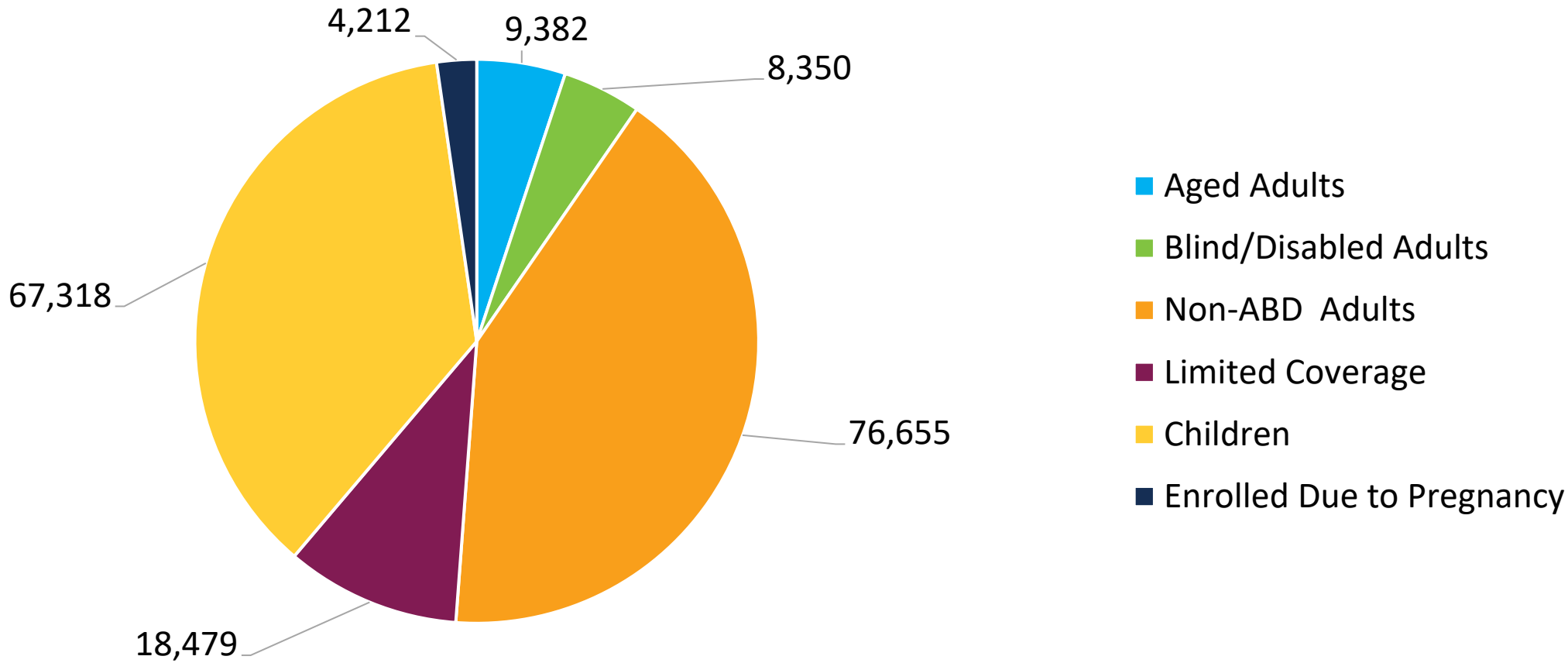
Top Closure Reasons – Closures through 09/06/2023

While August marks the sixth month of unwinding, the first month renewals were due in Virginia was May 2023. Redeterminations that were received in April were processed, however, April did not include closures for failure to return Medicaid renewal packets. As of 09/06/2023, 105,870 members were closed for non-procedural reasons (ineligible) and 78,526 members were closed for procedural reasons (did not return a renewal form or verifications needed to determine eligibility). This total is through unwinding out of the 2,166,381 members identified in the unwinding cohort.



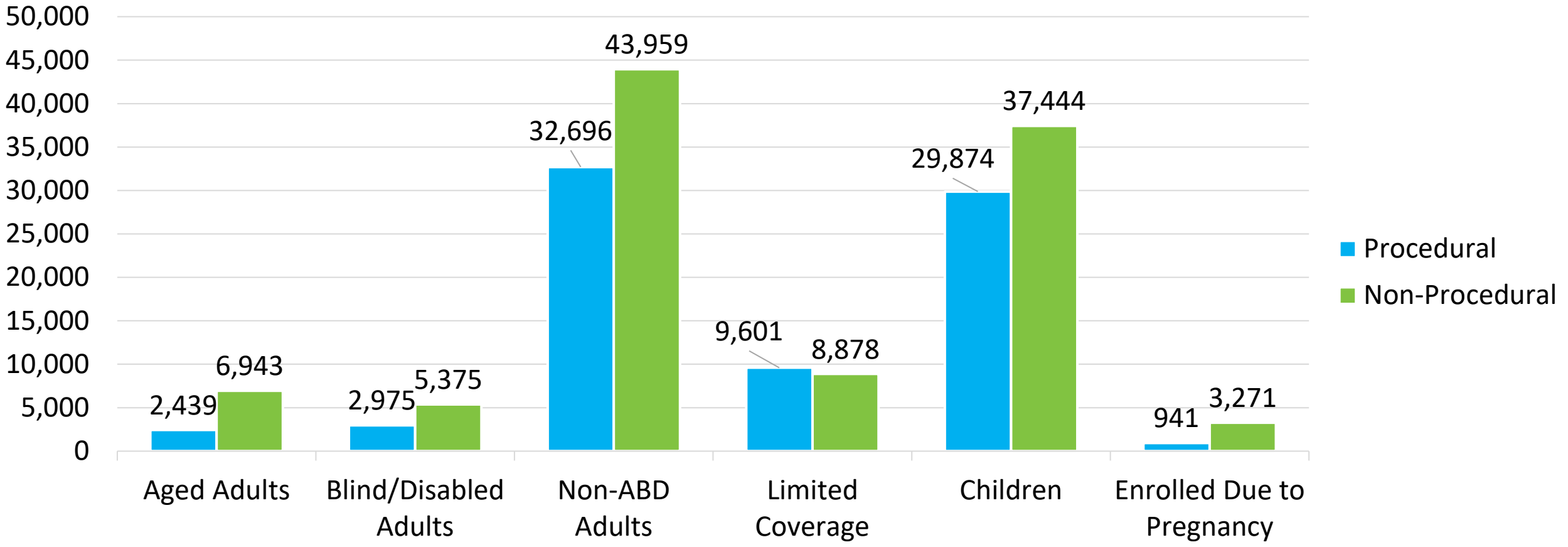
Top Closures by Eligibility Grouping: Closures through 09/06/2023

The highest closures happened among non-ABD adults (LIFC/Expansion), followed by children, and then those in limited coverage (MSP/Plan First/Incarcerated Coverage/Emergency Medicaid).



Procedural vs. Non-Procedural Closures by Eligibility Grouping: Closures through 09/06/2023

The highest closures happened among non-ABD adults (LIFC/Expansion), followed by children, and then those in limited coverage (MSP/Plan First/Incarcerated Coverage/Emergency Medicaid).

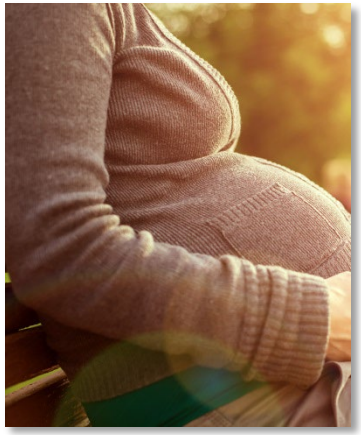


Information and Resources

- **Member and Stakeholder Resources and Material** can be found on the Cover Virginia, Cubre Virginia, and DMAS websites. The Return to Normal Enrollment page on each site contains toolkits, information, and resources for members, providers, and other stakeholders. to learn more about Virginia's preparation and important updates.
  - DMAS Website: https://www.dmas.virginia.gov/covid-19-response/
  - Cover Virginia Website: https://coverva.dmas.virginia.gov/return-to-normal-enrollment/
  - Cubre Virginia Website: https://cubrevirginia.dmas.virginia.gov/return-to-normal-enrollment/
- **Virginia's Unwinding Plan** can be found on the DMAS site on the COVID-19 page, describing the collaboration with internal and external stakeholders to cover all areas in preparation to return to normal enrollment.
  - The plan can be found at: https://www.dmas.virginia.gov/media/5948/dmas-unwinding-operational-plan.pdf
- **The Renewal Status Dashboard** can be found on the DMAS site under the Data tab that tracks the progress toward redetermining Virginia's Medicaid population on a monthly basis.
  - The dashboard can be found at https://www.dmas.virginia.gov/data/return-to-normal-enrollment/eligibility-redetermination-tracker/
- **Legislator Resources and Information** can be found on the DMAS website at: https://www.dmas.virginia.gov/about-us/legislative-office-resources/
  - New dashboards are available which provide enrollment data by Virginia State House and Senate districts as well as Congressional districts.

Thank you to all partners across the Commonwealth who are working to support the efforts to ensure a smooth transition back to normal processing.





FINANCE UPDATE

Chris Gordon
CFO / Deputy for Finance
DMAS
September 2023

2023 Special Session I

New Rates (8)	FY2024		
	GF	NGF	Total
5% Rate Increase for Personal Care, Respite, and Companion Services for Consumer Directed and Agency Directed (304.YYYY)	20,808,161	23,597,067	**44,405,228**
10% Rate Increase for Certain Community-Based Behavioral Health Services on January 1, 2024 (304.VVVV.1 & 2)	8,699,568	18,486,674	**27,186,242**
Fund Complex Rehab. Tech. for Medicaid Nursing Facility Members	1,272,060	1,335,690	**2,607,750**
Increase Rates for Early Intervention Services, Excluding Case Management, by 12.5% for Children under Three on January 1, 2024 (304.TTTT)	558,509	593,974	**1,152,483**
Medicaid Parity of Mental Health and Substance Use Disorder Rates (304.WWWW)	218,918	679,354	**898,272**
Medicaid Dental Program Enhancements (304.XXXX)	$ 214,136	$ 347,386	**$ 561,522**
Collaborative Care Management Services for Substance Use Treatment (304.AAAAA)	21,589	191,917	**213,506**
EPSDT Therapeutic Group Homes Rate Increase for Grafton RTF on January 1, 2024 (304.RRRR)	$ 100,330	$ 109,029	**$ 209,359**

Source: HB6004, 2023 Special Session I

2023 Special Session I

New Programs (2)	FY2024		
	GF	NGF	Total
Implement Modified Emergency Room Utilization Program on January 1, 2024 (304.HHH)	-	-	-
Implement Medicaid Private Hospital Supplemental & IME Payments on January 1, 2024 (304.DD.10.c-d & 11)	-	-	-

Additional Supplemental Payment	FY2024		
	GF	NGF	Total
Increase Children's Hospital of The King's Daughters Payments by Adjusting IME Case Mix Effective July 1, 2023 (304.UUUU)	5,153,878	5,896,122	**11,050,000**

Source: HB6004, 2023 Special Session I

2023 Special Session I

New DD Waiver Slots	FY2024		
	GF	NGF	Total
Add 500 Developmental Disability (DD) Waiver Slots on January 1 (304.J.4.a)	7,577,559	7,911,345	**15,488,904**

New Pharma Oversight	FY2024		
	GF	NGF	Total
Service Authorization & Reporting for Weight Loss and Diabetic Drugs (304.ZZZZ.1-2)	-	-	**-**

Managed Care Reprocurement Authorization	FY2024		
	GF	NGF	Total
Medicaid Managed Care Reprocurement (308.EE.1-4)	-	-	**-**

Source: HB6004, 2023 Special Session I

Key Takeaways

- All Budget Items may require:
  - Project plan
  - Authority (CMS SPA, Waiver, Pre-print)
  - Rate changes (capitation, FFS)
  - Systems changes (SIT, UAT, production)
  - Contract and vendor changes
  - Other agencies (state, local, stakeholders)
  - Readiness reviews
  - Communications (memo, bulletins)

Regulatory Activity Summary September 12, 2023
(* Indicates Recent Activity)

2023 General Assembly

***(01) Pharmacists as Providers:** In accordance with SB 1538 of the 2023 General Assembly, the state plan is being revised to provide reimbursement to a pharmacist, pharmacy technician, or pharmacy intern when services are (i) performed under the terms of a collaborative agreement as defined in § 54.1-3300 and consistent with the terms of a managed care contractor provider contract or the state plan or (ii) related to services and treatment in accordance with § 54.1-3303.1. The SPA is currently circulating for internal review.

***(02) Third Party Liability:** The purpose of this state plan amendment is to add language that is needed to respond to a CMS State Medicaid Director letter (#23-002) requiring Medicaid agencies to amend their state plan to provide assurances that the state has rules in place that bar liable third-party payers from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules. The SPA will also provide clarity relating to lien amounts arising from the Medicaid program and asserted against personal injury claims proceeds. Following internal review, the SPA was submitted to CMS for review on 9/1/23.

***(03) Supplemental Payments for Freestanding Children's Hospital Physician Services:** In accordance with the Medicaid State Plan (Supplement 6 to Attachment 4.19-B) and 12VAC30-80-300, supplemental payments for services provided by physicians at freestanding children's hospitals must be calculated using the Medicare equivalent of the average commercial rate (ACR) methodology prescribed by CMS. DMAS is required to recalculate the ACR every three years. The last ACR is dated July 1, 2020, and CMS requires DMAS to submit a new ACR calculation effective July 1, 2023. After performing calculations based on data provided by the Virginia freestanding children's hospitals, DMAS determined that the ACR must be increased from 178% of Medicare to 191% of Medicare. Following internal review, this state plan amendment was submitted to CMS for review on 7/24/23.

***(04) Nursing Facility Value-Based Purchasing Program:** This SPA will allow DMAS to revise the nursing facility (NF) value-based purchasing (VBP) program for year two of the program. In accordance with the 2022 Special Session, Item 304.OOO, DMAS revised the state plan in 2022 to establish a unified, value-based purchasing (VBP) program that includes enhanced funding for facilities that meet or exceed performance and/or improvement thresholds as developed, reported, and consistently measured by DMAS in cooperation with participating facilities. During the first year of this program, half of the available funding was distributed to participating nursing facilities to be invested in functions, staffing, and other efforts necessary to build their capacity to enhance the quality of care furnished to Medicaid members. This funding was administered as a Medicaid rate add-on. The remaining funding was allocated based on performance criteria as designated under the nursing facility VBP program. Pursuant to the 2022 Special Session, Item 304.OOO, DMAS will revise the state plan again to reflect the second year of the nursing facility VBP program. The amount of funding devoted to nursing

facility quality of care investments shall be 25 percent of available funding in the second year of the program before the program transitions to payments based solely on nursing facility performance criteria in the third year of the program. In the third year of this program, such funds as appropriated for this purpose shall be fully disbursed according to the aforementioned unified VBP arrangement to participating nursing facilities that qualify for the enhanced funding. The project is currently circulating for internal review.

(05) Removal of DATA Waiver (X-Waiver): Section 1262 of the Consolidated Appropriations Act, 2023, removed the federal requirement that practitioners obtain a DATA-Waiver or X-Waiver to prescribe medications, like buprenorphine, to treat patients with opioid use disorder. Accordingly, the state plan is being revised to allow providers who have a current license to practice and a Drug Enforcement Administration (DEA) registration authorizing the prescribing of Schedule III drugs to prescribe buprenorphine for the treatment of opioid use disorder or pain management. Following internal review, the SPA was submitted to CMS for review on 8/30/23.

***(06) Targeted Case Management for Individuals with Traumatic Brain Injury:** In accordance with House Bill 680 of the 2022 legislative session and the 2022 Appropriations Act, DMAS is revising the state plan to include a provision for the payment of targeted case management for individuals with severe brain injury. The project is currently circulating for internal review. Implementation planning is underway to begin provider enrollment activities and service delivery in state fiscal year 2023. Following internal review, the project was submitted to CMS for review on 6/30/23.

***(07) State-Based Exchange:** This state plan amendment explains that The Virginia General Assembly passed legislation creating the Health Benefit Exchange Division within the State Corporation Commission to oversee Virginia's transition to a Virginia State Based Exchange (SBE). The SBE is expected to go live in November, 2023. One element of this project is that DMAS must file a SPA to reflect the presence of the SBE in Virginia.

The SPA notes that the exchange will:
"… conduct Medicaid eligibility determinations for groups of individuals whose income eligibility is determined based on Modified Adjusted Gross Income (MAGI) methodology and who apply through the SBE. The SBE will not be assigning an individual who is determined eligible for Medicaid whose income eligibility is determined using MAGI methodology to a specific eligibility group, determining cost sharing (if applicable) or assigning a benefit package. These functions will be performed by the single state agency. The SBE also refers individuals to the single state agency for determination if potentially eligible for non-MAGI Medicaid (e.g. ABD or limited coverage) or if potentially eligible for MAGI coverage but the exchange was unable to make a full determination. The SBE will not be handling appeals." Following internal review, the SPA was submitted to CMS for review on 5/12/23. The SPA was approved on 8/7/23.

***(08) Electronic Visit Verification (EVV) for Home Health:** The purpose of this SPA is to incorporate changes to the state plan text in accordance with the requirements of the Social Security *Act* (SSA) § 1903(l) regarding EVV as applicable to home health care services across all mandates of the SSA and the *Cures Act*. Virginia is in compliance with section 12006 of the

21st Century CURES Act, which required states to implement EVV for personal care services by January 1, 2020. Section 12006 of the CURES Act requires states to implement EVV for Home Health Care Services (HHCS) by January 1, 2023. Virginia applied for and received a one-year Good Faith Effort (GFE) exemption for HHCS. As a result, Virginia implemented EVV for Home Health Care Services on July 1, 2023. Following internal review, the SPA was submitted to CMS on 8/28/23.

***(09) Case Management for Assisted Living Facility Residents:** This SPA will allow DMAS to remove outdated case management language for assisted living facility residents from the state plan. DMAS has not provided this service for several years, so the state plan needs to be updated accordingly. Following internal review, the SPA was submitted to CMS on 7/3/23.

***(10) Repeal of Documents Incorporated by Reference (Chapter 60):** This regulatory action is being carried out in accordance with Governor Youngkin's Executive Order #19. DMAS completed an internal review of 12VAC30-60 and determined that all of the documents incorporated by reference are either outdated or already exist on the DMAS Medicaid Enterprise System (MES) Web Portal or via other sources that are not owned by DMAS (e.g., the DSM). Therefore, referencing them in the Virginia Administrative Code is unnecessary and they should be repealed. This regulatory action is being promulgated to repeal out-of-date and unnecessary regulations. Following internal review, this regulatory action was submitted to the OAG on 7/19/23.

***(11) Provider Appeals:** The purpose of this regulatory action is to clarify when documents are considered filed and adds the Appeals Information Management System (AIMS) to the Virginia Administrative Code in accordance with the DMAS current provider appeals practices. Following internal review, this project was submitted to the OAG on 2/1/23 and certified by the OAG on 6/12/23. The reg project was submitted to DPB on 6/22/23 and to HHR on 7/25/23.

(12) Repeal of Out-of-Date and Unnecessary Regulations: This regulatory action is required in accordance with Governor Youngkin's Executive Order #19. DMAS has completed an internal review of these regulations and has determined that all of the content already exists in the DMAS Eligibility and Enrollment Manual on the DMAS webpage, and that these regulations are redundant and unnecessary, and should be repealed. Following internal review, the project was submitted to the OAG for review on 1/30/23.

***(13) OTC Drugs:** This SPA is required based on the CMS' request for Virginia to change the language related to over-the-counter (OTC) drugs. CMS asked DMAS to include the following sentence in order to indicate where a list of OTC drugs could be located: "A list of specific covered drug categories is published in Chapter 4 of the Pharmacy Provider Manual." With this new language, DMAS no longer needs, and proposes deleting the following language: "2. Non-legend drugs shall be covered by Medicaid in the following situations: a. Insulin, syringes, and needles for diabetic patients; b. Diabetic test strips for Medicaid recipients under 21 years of age; c. Family planning supplies; d. Designated categories of non-legend drugs for Medicaid recipients in nursing homes…" (These items will remain covered, but they will be stated with specificity in the Pharmacy Manual and do not need to be repeated in the state plan.) CMS also asked that Virginia remove language related to home infusion therapy from the pharmacy

section of the state plan. That language is already in the durable medical equipment section of the state plan, so removing the language from the pharmacy section has no practical effect. Following internal review, the SPA was submitted to CMS on 4/24/23 and approved on 5/18/23. The corresponding regulatory project was submitted to the OAG for review on 7/31/23.

***(14) Average Commercial Rate for Physicians Affiliated with Type 1 Hospitals:** In accordance with the 2022 Appropriations Act, Item 304.B(4), DMAS "… shall have the authority to amend the State Plan for Medical Assistance to increase physician supplemental payments for physician practice plans affiliated with Type One hospitals up to the average commercial rate [ACR] as demonstrated by University of Virginia Health System and Virginia Commonwealth University Health System…". In addition, this SPA will satisfy the DMAS requirement to recalculate the ACR every three years. The last ACR is dated April 1, 2020, and CMS requires DMAS to submit a new ACR calculation effective April 1, 2023. Following internal review, the SPA was submitted to CMS on 4/14/23 and approved on 5/19/23. The corresponding reg action is presently on hold.

2022 General Assembly

(01) Removal of Cost Sharing: The purpose of this regulatory action is to remove co-payments for Medicaid and FAMIS enrollees in accordance with a General Assembly mandate. The 2022 Appropriations Act, Item 304.FFFF, required DMAS to remove co-payments for Medicaid and FAMIS enrollees effective, April 1, 2022. DMAS has not been imposing co-payments on Medicaid and FAMIS members during the federal public health emergency (PHE) related to the Coronavirus Disease 2019 (COVID-19) pandemic. However, as of a result of 2022 Appropriations Act, Item 304.FFFF, co-payments have been permanently removed and they will not be reinstated after the federal PHE ends. Following internal review, the reg project was submitted to the OAG for review on 3/21/23.

(02) Post Eligibility Special Earnings: The 2022 Appropriations Act, Item 304.ZZ, requires DMAS to adjust the post eligibility special earnings allowance for individuals in the Commonwealth Coordinated Care Plus (CCC Plus), Community Living (CL), Family and Individual Support (FIS), and Building Independence (BI) waiver programs to incentivize employment for individuals receiving waiver services. The purpose of this action is to incentivize employment for individuals receiving DD waiver services by allowing a percentage of earned income to be disregarded when calculating an individual's contribution to the cost of their waiver services when earning income. This enables individuals enrolled in the DD waiver to keep more of their income, without losing financial eligibility for the waiver. This does not result in new individuals being added to the DD waiver. The project was submitted to the OAG for review on 2/7/23.

(03) Medicaid Enterprise System: The purpose of this final exempt regulatory action is to make technical updates to several of the agency's regulations to reflect the Department's transition of several key information management functions handled through the Virginia Medicaid Management Information System (VAMMIS) to a new technology platform called the Medicaid Enterprise System (MES). The MES replaced the department's VAMMIS on April 4, 2022. The reg project was posted to the Town Hall on 3/7/23 for OAG review.

***(04) Preventive Services:** Item 304.EEEE in the 2022 Appropriations Act requires DMAS to "amend the State Plan under Title XIX of the Social Security Act, and any waivers thereof as necessary to add coverage of the preventive services provided pursuant to the Patient Protection and Affordable Care Act (PPACA) for adult, full Medicaid individuals who are not enrolled pursuant to the PPACA." Following internal review, the DPB and Tribal notices were sent for review on 8/30/22. The SPA was submitted to CMS on 9/30/22 and approved by CMS on 12/7/22. Following internal review, the corresponding reg project was submitted to the OAG for review on 7/27/23.

(05) Institutional Provider Reimbursement Changes: The 2022 Appropriations Act requires DMAS to make several institutional (inpatient and long-term care) changes to the state plan. Following internal review, the SPA was submitted to CMS for review on 9/2/22. The SPA was approved by CMS on 11/23/22. The regulatory review phase of the project is currently on hold.

(06) Non-Institutional Provider Reimbursement Changes: The 2022 Appropriations Act requires DMAS to make several changes to non-institutional provider reimbursement. Following internal review, the SPA documents were forwarded to DPB and to the Tribal Programs for review on 8/19/22. The SPA was submitted to CMS for review on 9/19/22. A request for additional information (RAI) was received from CMS on 12/14/22. Draft RAI responses were sent to CMS for review on 1/19/23 and the final RAI response was forwarded to CMS on 2/17/23. The SPA was approved on 3/14/23. The regulatory review phase of the project is currently on hold.

(07) Third Party Liability Update: This state plan amendment is needed in order to respond to a CMS Informational Bulletin requiring states to "ensure that their Medicaid state plans comply with third party liability (TPL) requirements reflected in current law." Virginia's TPL text required updates to reflect current law. The SPA was submitted to CMS on 6/27/22 and approved on 7/25/22. Following internal review, the corresponding fast-track project was submitted to the OAG for review on 12/13/22. Revised regs were sent to the OAG for review on 5/30/23.

(08) PACE (Rates & Payment Methodology): DMAS has revised the state plan to update sections that pertain to the Program of All-Inclusive Care for the Elderly (PACE). Specifically, this SPA (1) incorporates the Rates and Payments language from the Center for Medicare & Medicaid Services' (CMS') most current PACE State Plan Amendment Pre-Print and (2) updates the PACE Medicaid capitation rate methodology to align with DMAS' current rate setting practices. DMAS has transitioned from fee-for-service data to managed care encounter data for development of the amount that would otherwise have been paid. The PACE program will continue to operate in the same way that is has based on regulations in the Virginia Administrative Code, and there will be no changes for providers as a result of this SPA. Following internal DMAS review, the SPA was submitted to CMS on 3/3/22. The SPA was approved by CMS on 4/26/22. Following internal review, the corresponding regulatory action was submitted to the OAG for review on 6/29/22; to DPB on 10/13/22; and to the HHR on 11/16/22.

2021 General Assembly

(01) Mental Health and Substance Use Case Management: These regulation changes remove the limit on substance use case management for individuals in IMDs are to comply with the Medicaid Mental Health Parity Rule. The federal Mental Health Parity regulation can be found in 42 CFR 438.910(b)(1). Specifying that reimbursement is allowed, provided two conditions are met, for mental health and substance use case management services for Medicaid-eligible individuals who are in institutions, with the exception of individuals between ages 22 and 64 who are served in IMDs and individuals of any age who are inmates of public institutions, aligns DMAS regulations with 42 CFR 411.18(a)(8)(vii) and documents the Department's existing practices. Clarifying ISP review timeframes and grace periods, and clarifying CSAC-Supervisees can bill for substance use case management services, document existing DMAS practices, rather than changes in practices. Following internal review, the project was submitted to the OAG on 1/13/22. DMAS received OAG inquiries on 1/19/22 and responded to those on 1/27/22. The regulatory action was approved by the OAG on 2/23/22 and was forwarded to DPB for review on 2/24/22. The project was forwarded to HHR on 4/5/22.

(02) Personal Care Rate Increase: This state plan amendment updates the date of the personal care fee schedule on January 1, 2022, in accordance with Item 313.SSSS.3 of the 2021 Appropriations Act. (A corresponding rate increase of 12.5% will be provided for personal care services and for companion and respite services provided under home and community-based waivers, however, the increase is not included in a state plan amendment but via waiver documentation.) Following internal review, the SPA was submitted to CMS on 12/13/21 and approved on 4/28/22. The corresponding regulatory review is currently on hold.

(03) Private Duty Nursing Services Under EPSDT: This regulatory action updates the Virginia Administrative Code to include the following items related to private duty nursing, in accordance with a mandate from the 2021 General Assembly: services covered, provider qualifications, medical necessity criteria**,** and rates. This regulation establishes the regulatory framework for individuals with the need for high-intensity medical care. Having regulations in place (rather than just language in Medicaid manuals) helps ensure that the rules are clear and transparent, and that they are applied equally across providers, and across members. This reg action includes a service description, a list of service components, provider qualifications, and service limits (which includes references to the documents needed to establish medical necessity). Following internal review, the regs were submitted to the OAG on 8/6/21 and then to DPB on 4/6/22. After edits were made to the regulations, the project was re-submitted to the OAG on 4/26/22 and sent to DPB on 5/18/22. The project was forwarded to the Secretary's Office for review on 6/1/22. Following additional internal revisions, the regulations were sent back to HHR on 8/1/22.

***(04) Consumer-Directed Attendants:** This regulatory action incorporates the requirements of HB2137, which passed during the 2021 General Assembly. These regulations provide a paid sick leave benefit to attendants who provide personal care, respite, or companion services to Medicaid-eligible individuals through the consumer-directed model of service. The consumer-directed (CD) model is currently available for those services in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, Medicaid Works program, and three of Virginia's four 1915(c) Home-and-Community-Based Services Waivers: Community

Living, Family and Individual Supports, and Commonwealth Coordinated Care Plus. These regulations provide a framework to the paid sick leave benefit's eligibility process and procedures. Eligibility will be determined on a quarterly basis by the Fiscal-Employer Agent (F/EA). The F/EAs currently provide payroll and tax processing for the Consumer-Directed model for both fee-for-service and managed care individuals. Following internal DMAS review, the regs were sent to the OAG on 9/30/21. A conf. call with the OAG to discuss the project was held on 11/15/21. The OAG requested minor changes to the regs. The reg project was placed on hold for a few months awaiting any action by the General Assembly regarding this provision. DMAS reached out to the OAG to re-engage this project. The OAG sent additional revisions/questions on 9/12/22. DMAS forwarded responses to the OAG on 11/9/22. The OAG sent a request for additional edits on 12/6/22. DMAS coordinated the responses and submitted them to the OAG on 12/21/22. The OAG forwarded additional questions on 1/9/23. DMAS had placed the project on hold to review General Assembly outcomes to determine if pending legislation (SB 886) would impact this regulation. Edits were made to the project and the regulatory action was re-submitted for OAG review on 7/26/23.

(05) Client Appeals Update: This regulatory action seeks to comply with a 2021 General Assembly mandate that requires DMAS to clarify (i) the burden of proof in client appeals; (ii) the scope of review for de novo hearings in client appeals, and (iii) the timeframes for submission of documents and decision deadlines for de novo client hearings. Following internal DMAS review, the reg action was submitted to the OAG on 7/23/21; to DPB on 1/14/22; and to HHR on 1/27/22. The project moved the Gov. Ofc. on 7/13/22 and was approved by the Governor on 9/2/22. The regulations were sent to the Registrar on 9/6/22; were published in the Register on 9/26/22 and will be in effect until 3/7/24. The fast-track phase of this project, following internal review, was submitted to the OAG on 3/27/23.

(06) School Services: The purpose of this SPA is to adhere to the 2021 Appropriations Act, Items 313.EEEE and VVVV, which require DMAS to make changes to the state plan. These changes will: 1) increase the rates for psychiatric services by 14.7 percent for psychiatric services to the equivalent of 110 percent of Medicare rates; and 2) increase supplemental physician payments for a freestanding children's hospital serving children in Planning District 8. The total supplemental Medicaid payment shall be based on the Upper Payment Limit approved by CMS and all other Virginia Medicaid fee-for-service payments. The project was submitted to CMS on 10/18/21. The request for additional information (RAI) for this project was received from CMS on 1/4/22. DMAS' RAI response was sent to CMS on 3/30/22. DMAS withdrew the RAI response and continues to work with CMS "off the clock" on this project.

(07) DSH Changes for Children's Hospitals: DMAS seeks to create additional hospital supplemental payments for freestanding children's hospitals with greater than 50 percent Medicaid utilization in 2009 to replace payments that have been reduced due to the federal regulation on the definition of uncompensated care costs, effective June 2, 2017. As part of this SPA, these new hospital supplemental payments, for freestanding children's hospitals, shall equal what would have been paid to the freestanding children's hospitals under the current disproportionate share hospital (DSH) formula without regard to the uncompensated care cost limit. These additional hospital supplemental payments shall take precedence over supplemental payments for private acute care hospitals. If the federal regulation is voided, DMAS shall continue DSH payments to the impacted hospitals and adjust the additional

hospital supplemental payments authorized, accordingly. Following internal review, the DPB and Tribal notices for this SPA were submitted on 5/6/21. DPB approved the SPA on 5/10/21 and the project was submitted to HHR on 5/18/21. Following HHR approval on 5/20/21, the SPA was submitted to CMS on 6/7/21. Informal questions were received from CMS on 7/12/21 and responses were forwarded to CMS on 7/19/21. The SPA was approved by CMS on 8/24/21. The corresponding regulatory action was circulated for internal DMAS review and submitted to the OAG for review on 9/28/21. The OAG sent additional question on 10/7/21 (DMAS response provided on 10/12/21) and 10/12/21 (DMAS response provided on 10/13/21). These regulations are currently on hold.

(08) Clarifications for Durable Medical Equipment and Supplies – Revisions: This state plan amendment proposes to amend a previous SPA. DMAS previously submitted SPA 20-011 entitled "Clarifications for Durable Medical Equipment and Supplies" which was approved by CMS on October 20, 2020. Following the approval of SPA 20-011, CMS discovered duplicative wording and the necessity to re-categorize a heading on multiple pages, and also requested that DMAS submit a new SPA to revise the text on those pages. There is no change to the content or meaning of the state plan text as a result of the change. Following internal review, and the submission of the DPB and Tribal Programs notifications, the SPA was forwarded to HHR for review on 3/8/21. The SPA was approved by CMS on 5/24/21. The corresponding regulatory action was circulated for internal review and submitted to the OAG on 8/26/21. The project was re-submitted to the OAG for review on 8/11/22.

(09) Adult Dental: The purpose of this SPA is to align with Item 313.IIII in the 2020 Virginia Appropriations Act, which requires DMAS to provide a comprehensive dental benefit to adults, effective July 1, 2021. The DPB and Tribal Programs notifications were forwarded on 2/22/21. The SPA was submitted to CMS on 3/25/21. The SPA was approved on 6/14/21, with an effective date of 7/1/21. The corresponding regulatory action was circulated for internal review and submitted to the OAG on 6/23/21.

2020 General Assembly

***(01) Preadmission Screening and Resident Review (PASRR) Update:** In responding to the legislative mandate of the General Assembly, the purpose of this regulatory action is to establish regulatory requirements for (i) allowing qualified nursing facility staff to complete the LTSS screening for an individual who applies for or requests LTSS, and who is receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital; and (ii) protecting an individual's choice for institutional or community based services and choice of provider. Following internal review, the project was submitted to the OAG for review on 1/5/21. Questions were received from the OAG on 3/24/21 and revisions were forwarded on 4/14/21. Additional revisions were submitted on 4/28/21. The project was submitted to DPB for review on 6/16/21 and to HHR on 6/29/21. The regs were forwarded to the Governor on 11/20/21 and approved on 12/21/21. The project was submitted to the Registrar on 12/22/21; published in the Register on 1/17/22; and became effective on 2/16//22. The emergency regs will be in effect until 8/15/23. Following internal review, the fast-track stage of the reg project was submitted to the OAG for review on 12/8/22. DMAS received inquiries from the OAG on 12/16/22, 1/3/23, 1/9/23, 1/25/23, 2/9/23, 2/13/23, 3/2/23, and 3/13/23.

DMAS submitted responses to the multiple OAG requests for edits and is awaiting further direction. On 6/15/23, DMAS requested an emergency reg extension and notified the OSHHR of the request. On 6/20/23, the Gov. Ofc. approved extending the emergency regulation until 2/14/24.

(02) 90-Day Prescriptions: The recent Medicaid Disaster Relief SPA allowed DMAS to provide 90-day prescriptions to Medicaid members (excluding Schedule II drugs), however, that SPA will end on the last day of the federal-declared emergency period. DMAS is filing a SPA to allow for the provision of a maximum of a 90-day supply for select maintenance drugs dispensed to Medicaid members (excluding Schedule II drugs) after the end of the federal emergency period. The 90-day supply will be available to Medicaid members after the member has received two (2) fills of 34 days or less of the drug. Following internal review, the SPA was filed with CMS on 11/9/20 and approved on 12/10/20. Following internal review, the corresponding regulatory action was submitted to OAG on 1/28/21. Status inquiries were forwarded to the OAG on 7/1/21, 8/10/21, 8/24/21, 9/14/21, 1/25/22, 3/9/22, 4/13/22, and 7/12/22. The project's economic impact form was uploaded to the Town Hall on 9/30/22.

(03) 2020 Long Term Services and Supports (LTSS) Screening Changes: For this reg project, the Code of Virginia, §§ 32.1-330, 32.1-330.01, and 32.1-330.3 are being amended in accordance with 2020 HB/SB 902 to allow qualified nursing facility staff to complete the Long-Term Services and Supports (LTSS) screening for individuals who apply for or request LTSS, and who are receiving non-Medicaid skilled nursing services in an institutional setting following discharge from an acute care hospital. The amendments to the Code include the protection of individual choice for the setting and provider of LTSS services for every individual who applies for or requests institutional or community based services. Following internal review, the regulations were submitted to the OAG for review on 11/18/20. Questions were received from the OAG on 3/24/21 and revisions were forwarded on 4/1/21 and 4/14/21. DMAS submitted the project to DPB on 6/14/21. Questions were received on 6/21/21 and responses were sent to DPB on 6/21/21. A conf. call was held on 6/22/21 to discuss the project. The reg action was submitted to HHR on 6/23/21. The regs were forwarded to the Governor on 11/10/21 and approved on 12/21/21. The project was submitted to the Registrar on 12/22/21 (w/ corrections sent on 12/29/21); published in the Register on 1/17/22; and became effective on 2/16//22. The emergency regs will be in effect until 8/15/23. Following internal DMAS review, the fast-track stage regs were submitted to OAG on 7/26/22. DMAS received comments from the OAG on 10/4/22. DMAS sent revisions to the OAG on 10/7/22. The project was submitted to DPB on 10/13/22 and DMAS responded to DBP questions on 10/18/22 and made additional revisions. The project's economic impact form was uploaded to the Town Hall on 10/13/22. A conference call with DPB was held on 11/7/22 to discuss the project. The reg action was submitted to HHR for review on 11/21/22. The agency response to DPB's economic impact analysis was posted to the Town Hall on 11/29/22.

(04) Update Average Commercial Rate (ACR) for Physicians Affiliated with Type One Hospitals: DMAS is required to recalculate the ACR every three years. The last ACR is dated April 1, 2017, and CMS requires DMAS to submit a new ACR calculation, effective April 1, 2020. After performing calculations based on data provided by Type One hospitals, DMAS determined that the ACR must be reduced from 258% of Medicare to 236% of Medicare. The DPB notification for this SPA was sent to DPB on 4/20/20. Following internal review, the SPA

binder was forwarded to HHR for review on 5/20/20 and to CMS on 5/28/20. CMS approved the SPA on 7/31/20. Following internal review, the corresponding regulatory action was submitted to the OAG on 1/27/21. These regulations are currently on hold.

2017 General Assembly

***(01) CCC Plus WAIVER:** DMAS has requested federal approval to merge the current Elderly or Disabled with Consumer Direction waiver population with that of the Technology Assistance Waiver, under the Commonwealth Coordinated Care Plus (CCC+) program. This regulatory action seeks to streamline administration of multiple waiver authorities by merging the administrative authority of two §1915(c) HCBS waivers into one §1915(c) waiver to be known as the Commonwealth Coordinated Care Plus (CCC+) waiver. The proposed merger of the EDCD waiver and Tech waivers will not alter eligibility for the populations and will expand the availability of services to encompass those currently available in either waiver to both populations. These populations will be included in the overall CCC+ program. The CCC+ Program will operate under a fully integrated program model across the full continuum of care that includes physical health, behavioral health, community based, and institutional services. CCC+ will operate with very few carved out services. Further, through person-centered care planning, CCC+ health plans are expected to ensure that members are aware of and can access community based treatment options designed to serve members in the settings of their choice. This action is essential to protect the health, safety, and welfare of citizens in that it allows for care coordination for the high-risk dually eligible population and ensures access to high quality care. The program includes systems integration, contract and quality monitoring, outreach, and program evaluation. The reg project was processed and reviewed internally. The action was submitted to the OAG for review on 11/9/17. Responded to OAG inquiries on 12/7/17, and additional inquiries on 2/22/18, 3/19/18, 4/10/18, and 5/16/18. The regs were approved by the OAG and forwarded to the Governor's Ofc. for review on 6/19/18. The emergency regulations were signed by Governor and became effective on 6/29/18, and published in the Register on 7/23/18. The NOIRA comment period was held between 7/23/18 - 8/22/18. An ER Extension request was submitted on 10/16/18, and the ER was extended through 6/28/20. Following internal DMAS review, the proposed stage of the regulatory action was submitted to the OAG on 3/2/21; to DPB on 12/6/21; to HHR on 1/19/22; and to the Governor's Ofc. on 6/1/22. Following approval from the Gov. Ofc., the project was submitted to the Registrar on 11/2/22 and was published in the Register on 12/5/22. Following the internal review of the final stage phase of the project, the regulations were submitted to DPB on 7/18/23 and to HHR on 8/7/23.

2015 General Assembly

(01) Barrier Crimes Not Permitted: This fast-track regulatory action is required by the 2016 budget language. This regulatory action will amend existing regulations relating to provider requirements. Current regulations do not specifically bar all providers who have been convicted of barrier crimes from participating as Medicaid or FAMIS providers. These regulatory changes bar enrollment to, or require termination of, any Medicaid or FAMIS provider employing an individual with at least 5 percent direct or indirect ownership who has been convicted of a barrier crime. The regulations were drafted, reviewed internally, and submitted to the OAG for review on 2/17/2017. The OAG issued inquiries on 3/21 and a conference call occurred on 4/26/17 to discuss the regs. The action had been placed on hold. Regulatory processing began again on 4/26/18 with a conf. call with the OAG. Revised text was forwarded to the OAG on 11/28/18 and an additional conf. call took place on 11/29/18. Additional revisions were sent to the OAG on 1/15/19. Another conf. call was held on 8/9/19 and revised regs were sent to the OAG on 8/16/19 for review. The project has again been placed on hold.

Items that have completed both their state regulatory process and their federal approval process, if a federal approval process was necessary, have been dropped off of this report.